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03/20/2008 02:25 FAX 2024429430

HR A

PRINTED: 03/20/2008 FORM APPROVED

DEPARTMENT OF HE/ LTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDIC ARE & MEDICAID SERVICES (XX)) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 03/07/2008 09G171

in

NAME OF PROVIDER OR SUPF JER

CARECO 11

STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE

PROVIDER'S PLAN OF CORRECTION

WASHINGTON, DC 20002

	(X4) ID PREFIX TAG	(EACH DEFI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROFRIATE DEFICIENCY)	COMPLETION DATE
ŀ	W 000	INITIAL COM	MENTS	W 000		
		March 5, 2008 fundamental s deficient pract of Active Trea examine this three clients v	n survey was conducted from through March 7, 2008 using the urvey process. However due to ces in the Condition of Participation ment, the survey was extended to ondition. A random sample of as selected from a residential ver females with mental retardation bilities.	-	2003 3 3 0	MINOV HLIVSH HLIVEGE HEAL
	W 120	observations interviews wit records, inclu	f the survey were based on it the home and two day programs, clients and staff, and the review of ling incident reports. SERVICES PROVIDED WITH JRCES	W 120	U	ETRATION STRATION STRATION
	•		st assure that outside services s of each client.		with the appropriate staff at the day program.	

This STAND/ RID is not met as evidenced by: Based on observations, Interview, and record verification, the facility failed to ensure that

PUMPER A STATEMENT OF DEDICIENCIES

outside services met the needs for one of three clients include in the sample, (Client #3)

The finding in :ludes:

On March 5, 1008 at 6:20 PM, Client #3 was observed eating a chopped dinner. On March 6, 2008 at approximately 12:00 PM, the client was observed during lunch at her day program. The client was obterved eating a chopped chicken, whole black treans, greens and a whole dinner roll. Interview with the Qualified Mental Retardation P ofessional (QMRP) and Registered Nurse on Mar :h 6, 2008 at approximately 2:30

ABORATORY DIRECTOR'S OR 'RIDVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

4/30/08

program participation.

Any deficiency statement endir a with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide suffic arr: protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey while there or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these discuments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Previous 1 ersions Obsolete

Event ID: HDM¢11

Facility ID: 09G171

If continuation sheet Page 1 of 16

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/20/2008 FORM APPROVED OVB NO. 0938-0391

CENTER	S EOP MEDIC	AFIE & MEDICAID SERVICES						<u>O VIB NO. 0938-0391</u>	
TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION					ULTIP	DLE CONSTRUCTION	(X:) DATE SURVEY COMPLETED		
	•	09G171			<u></u>		03/07/2008		
NAME OF PROVIDER OR SUPP					STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002				
(X4) ID PREFIX TAG	(EACH DEFIC	EMC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	1X	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULC BE	(X5) COMPLETION DATE	
W 120	due to her rish client's curren confirmed that chopped diet. 483.420(a)(2) RIGHTS The facility multiple for the parent (if the of the client's and behavior	the of a pay the ⊃RC st e facilism ned il sta	age 1 client received a chopped diet spiration. Review of the sician's order at 2:00 PM client was required to receive a DTECTION OF CLIENTS Insure the rights of all clients, ity must inform each client, it is a minor), or legal guardian, ical condition, developmental atus, attendant risks of the right to refuse treatment.	,	124				
	Based on obs. review, the far would ensure risks and ben the three clier #3)	acya :ility :tier :firs ts in	is not met as evidenced by: tion, staff interview, and record failed to establish a system that its that were informed of their of their medication for two of the sample. (Clients #1 and			; ;			
	observed dur- being adminis mg. Interview (LPN) at appi client was pre- behavioral ma current physic client was pre- medication.	5, 20 ng there with exim scrit mag ian's scrit 'unth	de: 008 at 5:23 PM, Client #1 was the evening medication pass of Ativan 2 mg and Risperdal 2 the Licensed Practical Nurse tately 5:45 PM revealed that the ded these medications for the ement. Review of Client #1's to orders confirmed that the the aforementioned the aforementioned the interview with the LPN the dications were incomprated			1. The QMRP will ensure that the clier decision-maker is informed in writing benefits and risks of recommended tree will obtain written consent for such tre	of : he health aur ents and	4/30/08	

into the cilent's Behavior Support Plan (BSP)

DEPARTMENT OF HE LITH AND HUMAN SERVICES

03/20/2008 02:25 FAX 2024429430

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PRINTED: 03/20/2008 FORM APPROVED CMB NO. 0938-0391

CENTERS FOR MEDIC AIRE & MEDICAID SERVICES			HRVEY					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
	·		09G171	B, Wil	NG _		03/07/2008	
NAME OF P	ROVIDER OR SUPF	JER			1	REET ADDRESS, CITY, STATE, ZIP CODE 701 24TH STREET. NE WASHINGTON, DC 20002		
	···)		
(X4) ID PREFIX TAG	(EACH DEEL	IEUC:	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	7IX	PROVIDER'S PLAN OF CORR. (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	(OULI) BE	(X5) COMPLETION DATE
W 124	dated Februa behaviors that physical aggridisrobing and Interview with entrance continvolved in he guardian. Reassessment of at revealed, the to make decishabilitation platinances, treawas no docummother had be and risks assessment of the psychotropic evidence that use of the psychotropic for Client #3's that the client medication: I revealed that Into the client dated Februa behaviors that behaviors, ph	/ 5, inclion hap the matter than the matter than the matter than the mental th	2008 to address targeted uded self-injurious behaviors, in, property destruction, propriate touching. Registered Nurse during the ce on March 5, 2008 at 3:45 Client #1's mother was very but was not the client's legal of the client's, psychological July 1, 2007 on March 6, 2008 e client did not have the ability on his behalf regarding ig, residential placement, it and medical matters. There ed evidence that Client #1's informed of the health benefits ed with the use of her cations. Also there was no mother had consented to the ropic medications and	W	124	2. See response to #1 above.		4/30/08

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If continuation sheet Page 3 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES

03/20/2008 02:25 FAX 2024429430

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2 SINTED: 03/20/2008	
FORM APPROVED	
рмв NO. 0938-039 <u>1</u>	

CENTERS FOR MEDIC ARE & MEDICAID SERVICES (X I) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 03/07/2008 09G171 STREET ADDRESS, CITY, STAYE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1701 24TH STREET, NE CARECO 11 WASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMALY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROFRIATE (EACH DEFIT IELICY MUST BE PRECEDED BY FULL PREFIX DATE REGULATOR OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY W 124 W 124 Continued From page 3 Interview with the Registered Nurse during the entrance confurence on March 5, 2008 at 3:45 PM revealed 1 ial; Client #3's mother was very involved in he life but was not the client's legal guardian. Review of the client's, psychological assessment cated July 1, 2007 on March 6, 2008 at revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treal ment and medical matters. There was no docun ented evidence that Client #2's mother had been informed of the health benefits and risks assi diated with the use of her psychotropic I redications. Also there was no evidence that the mother had consented to the use of the psychotropic medications and corresponding BSP. 483,420(a)(7) PROTECTION OF CLIENTS W 130 W 130 RIGHTS The QMRP will provide retraining to staff on each person's right to privacy. The facility m ist ensure the rights of all clients. Therefore, the facility must ensure privacy during 4/3/18 treatment and caire of personal needs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that clients were provided privacy during care of personal neers for one of the three clients in the sample. (Clie it #2) The finding in: Judes: On March 5, 7008 at 3:25 PM, staff was observed changing Clie it:#2's adult protective

FORM CMS-2567(02-99) Provious \ antione Obsoleta

undergarmen s (APU's) in her bedroom with the door wide opened. The direct care staff did not close the door upon my entry into the hallway.

Event ID: HDMC11

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DEPARTMENT OF HEILTH AND HUMAN SERVICES

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03/20/2008 02:26 IAN 2024429430

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FRINTED: 03/20/2008 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES							CMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(23) DATE SU COMPLE		
			09G171	B. WI	NG_		03/07	7/2008
NAME OF PROVIDER OR SUPI L					17	EET ADDRESS, CITY, STATE, ZIP CODE 701 24TH STREET, NE /ASHINGTON, DC 20002		-
(X4) ID PREFIX TAG	(EACH DEFI	HENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEPICIENCY)	ひょう 8度	(X5) COMPLETION DATE
W 148	The surveyor doorway in classing the ducare staff atteclosing the du483.420(c)(6) CLIENTS, PATTHE facility imparents or guichanges in the limited to, ser or unauthorization of the standard o	stood ar vicing the mpt to or. COMRIENT is the original above the pare dents of the collection of the	in the client's bedroom we of the client being changed, he observation did the direct o protect Client #2's privacy by IMUNICATION WITH TS & of any significant incidents, or his condition including, but not liness, accident, death, abuse, sence. is not met as evidenced by: y and record review, the facility ents and/or guardians of s, for one of the three clients in t #2)		148	The QMRP will provide refresher train staff on incident management, includin notifications.		4/30/68

FORM CWS-2007(02-99) Frevious rersions Obsoleta

CLIENTS

Review of the unusual incidents on March 5, 2008, at approximately 2:15 PM revealed an incident date: January 17, 2008. The incident documented hat Client #3 hit Client #2 in the face. The incident failed to Indicate that the client's family was made aware of the incident.

Interview with the Qualified Mental Retardation Professional in March 7, 2008 at 10:00 AM acknowledge I the deficient practice.
W 153 483.420(d)(2 STAFF TREATMENT OF

The facility must ensure that all allegations of mistreatment neglect or abuse, as well as injuries of unknown source, are reported

Event ID; HDMC11

Feelily (0: 09G171

W 153

If continuation sheet Page 5 of 16

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03/20/2008 02:26 FAX 2024429430

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PRINTED: 03/20/2008 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES O VIB NO. 0938-0391 CENTERS FOR MEDIC ARE & MEDICAID SERVICES (X:) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION a. Euilding B. WING 03/07/2008 09G171 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPP JER 1701 24TH STREET, NE WASHINGTON, DC 20002 CARECO 11 PROVIDER'S PLAN OF CORRECTION (X\$) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULT BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFIX ENCY MUST BE PRECEDED BY FULL REGULATOR: OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PREFIX TAG DEFICIENCY TAG W 153 W 153 Continued From page 5 immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on inte view and record review, the facility failed to ensure that all unusual incidents including injur as of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, 5 action 3519.10) one of the three clients in the Licility. (Client #2) The findings include: 1. Review of he unusual incidents on March 5, 4/30/08 1. Sec response to W148. 2008, at appr_ximately 2:15 PM revealed an incident dated January 17, 2008. The incident documented I rail Client #3 hit Client #2 in the face. The incident failed to indicate that the State Agency, the clients family or the administrator was made aw are of the incident, 2. Review of he unusual incidents on March 5, 2008, at appr ximately 2:15 PM revealed an 2. See response to W148. incident dated November 15, 2007. The incident documented i nat Client #3 scratched Client #2 in the face. The incident failed to indicate that the administrator was made aware of the incident. Interview with the Qualified Mental Retardation

FORM CMS-2507(02-99) Previous - eraions Obsolete

CLIENTS

Professional in March 7, 2008 at 10:00 AM acknowledge: the deficient practice.

The results of all investigations must be reported

to the adminit traitor or designated representative

W 156 483,420(d)(4), STAFF TREATMENT OF

Event ID: HDMC11

Facility ID: 09G171

W 156

If continuation sheet Page 6 of 16

See response to W148

483.430(a) QUALIFIED MENTAL

RETARDATIC N PROFESSIONAL

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03/20/2008 02:26 TAX 2024429430

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FRINTED: 03/20/2008 FORM APPROVED

DEPARTMENT OF HE LITH AND HUMAN SERVICES 1 CMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 09G171 03/07/2008 NAME OF PROVIDER OR SUP! JER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE **CARECO 11** WASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION SUMMA Y STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH DEFI TENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATOR 'CR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROFINATE TAG DEFICIENCY) W 156 Continued From page 6 W 156 or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure the requilis of investigations were reported to the adminis rator or designee for two of the five clients residin (in the facility, (Clients #2 and #5)) The finding in diudes: Review of the unusual incidents and investigative reports on March 5, 2008, at approximately 2:15 PM revealed in unusual incidents dated January 1, 2008, January 17, 2008, February 11, 2008. November 15 2008, and November 26, 2007. The incidents were investigated, however, there was no evider certhat the administrator was made aware of the results of the investigations. Interview with the Qualified Mental Retardation Professional c n March 7, 2008 at 10:00 AM acknowledge: the deficient practice. W 159

W 159

************ *** RX REPORT *** **********

INCOMPLETE RECEPTION

TX/RX NO

9151

CONNECTION TEL

301 565 4541

CONNECTION ID

CARECO

ST. TIME

USAGE T

03/31 05:50

PGS.

01'41 8

RESULT

NG

##0201

FROM:

CARECO

HEALTH CARE PROVIDERS 8115 FENTON ST., SUITE 203 SILVER SPRING, MD 20910 (301) 565-9400 FAX (301) 565-4541

To: Patricia Vanburen Jeanine Carter

Fr: Marsha Thompson

Re: POC for 1761 Depth St. NE (Careco 11)

Please see attacked POC -

30 pages (including cour shed)

Any questions - pla contact me at 202812 2078

Manks!

Mar. 31 2008 05:00PM

P2/30

HRA

03/20/2008 02:25 FAX 2024429430

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	H AND HUMAN SERVICES			PRINTED: 03/20/2008 FORM APPROVED OMB NO. 0938-0391
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATÉ SURVEY COMPLETED
	08G171	B. WII	NG	03/07/2008
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	

CARECO	ROVIDER OR SUPPLIER 11		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002		
(X4) ID PREFIX YAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REBULATORY OR LEC IDENTIFYING INFORMATION)	,ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X4) COMPLETION DATE
W 000	INITIAL COMMENTS	W O	00		_i
W 120	A recertification survey was conducted from March 5, 2008 through March 7, 2008 using the fundamental survey process. However due to deficient practices in the Condition of Participation of Active Treatment, the survey was extended to examine this condition. A random sample of three clients was selected from a residential population of five females with mental retardation and other disabilities. The findings of the survey were based on observations at the home and two day programs, interviews with clients and staff, and the review of records, including incident reports. 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.	W 13	-	The QMRP will review the client's dietary needs with the appropriate staff at the day program.	4/30/08
	This STANDARD is not met as evidenced by: Based on observations, interview, and record verification, the facility failed to ensure that outside services met the needs for one of three clients include in the sample. (Client #3)				7/300
	The finding includes:				
	On March 5, 2008 at 6:20 PM, Client #3 was observed eating a chopped dinner. On March 6, 2008 at approximately 12:00 PM, the client was observed during lunch at her day program. The client was observed eating a chopped chicken, whole black beans, greens and a whole dinner roll. Interview with the Qualified Mental Retardation Professional (QMRP) and Registered Nurse on March 6, 2008 at approximately 2:30			Τιτιε	(X5) PATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HDMC11

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Mar. 31 2008 05:01PM P3/30

03/20/2008 02:25 FAX 2024429430

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
MAD 1 PAIN C	. 55///25//014		A. BUILDING			03/07/2008	
NAME OF P	ROVIDER OR SUPPLIER	09G171		17	EET ADDRESS, CITY, STATE, ZIP CODE 101 24TH STREET, NE VASHINGTON, DC 20002	00102	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR		PROVIDER'S PLAN OF CORRECT (FACH CORRECTIVE ACTION SHOTE)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG .					DEFICIENCY)		
W 120			W	120			
W 124	chopped diet. 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS			124			
	Therefore the facil parent (if the client of the client's med and behavioral st	nsure the rights of all clients, ity must inform each client, t is a minor), or legal guardian, ical condition, developmental atus, attendent risks of the right to refuse treatment.					
	Based on observa review, the facility would ensure clien risks and benefits	is not met as evidenced by: tion, staff interview, and record falled to establish a system that that were informed of their of their medication for two of the sample, (Clients #1 and					
	The findings include	de:					
	1. On March 5, 2008 at 5:23 PM, Client #1 was observed during the evening medication pass being administered Ativan 2 mg and Risperdal 2 mg. Interview with the Licensed Practical Nurse (LPN) at approximately 5:45 PM revealed that client was prescribed these medications for behavioral management. Review of Client #1's current physician's orders confirmed that the client was prescribed the aforementioned medication. Further interview with the LPN revealed that the medications were incorporated into the client's Behavior Support Plan (BSP)				1. The QMRP will ensure that the clier decision-maker is informed in writing benefits and risks of recommended tree will obtain written consent for such tree.	of the health atments and	4/30/08

FORM CMS-2587(02-99) Pravious Versions Obsolete

Event ID: HDMC11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/20/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
and Plan O	- CORRECTION		A. BUI B, WIN			n3/07	/2008
NAME OF P	ROVIDER OR SUPPLIER	09G171		17	EET ADDRESS, CITY, STATE, ZIP CODE 701 24TH STREET, NE (ASHINGTON, DC 20002		72000
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY PULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIETION OF THE APPR	JLD BE	(X5) COMPLETION DATE
W 124	behaviors that incluphysical aggression disrobing and inapple interview with the Fentrance conference. PM revealed that Convolved in her life guardian. Review assessment dated at revealed that the to make decisions habilitation planning finances, treatment was no documente mother had been in and risks associate psychotropic medic evidence that the ruse of the psychotropic corresponding BSF.	2008 to address targeted added self-Injurious behaviors, in, property destruction, propriate touching. Registered Nurse during the see on March 5, 2008 at 3:45 client #1's mother was very but was not the client's legal of the client's, psychological July 1, 2007 on March 6, 2008 at client did not have the ability on his behalf regarding g, residential placement, it and medical matters. There are evidence that Client #1's informed of the health benefits and with the use of her cations. Also there was no nother had consented to the ropic medications and and 2,	W	124	2. See response to #1 above.		
·	being administered mg and Seroquel 1 Licensed Practical 5:45 PM revealed the medications for being of Client #3's curred that the client was medication. Further evealed that the ninto the client's Being dated February 5, behaviors that inclied behaviors, physical	e evening medication pass I Buspar 15 mg, Depakote 500 100 mg. Interview with the Nurse (LPN) at approximately that client was prescribed these havioral management. Review int physician's orders confirmed prescribed the aforementioned ar interview with the LPN medications were incorporated havior Support Plan (BSP) 2008 to address targeted uded screaming, self-injurious I aggression, property ing and inappropriate touching.			2. See response to #1 above.		4130/08

FORM CM\$-2567(02-99) Previous Versions Obsolete

Event ID: HDMC11

Facility ID; 09G171

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Mar. 31 2008 05:01PM P5/30

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M. 31 2000 00.01111 10/3

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/GLIA

PRINTED: 03/20/2008 FORM APPROVED DMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G171	B. WING		03/07/2008	
NAME OF P	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, SYAYE, ZIP CODE 701 24TH STREET, NE VASHINGTON, DC. 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
W 124	Continued From pa	ge 3	W 124			
W 130	Interview with the Registered Nurse during the entrance conference on March 5, 2008 at 3:45 PM revealed that Client #3's mother was very involved in her life but was not the client's legal guardian. Review of the client's, psychological assessment dated July 1, 2007 on March 6, 2008 at revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that Client #2's mother had been informed of the health benefits and risks associated with the use of her psychotropic medications. Also there was no evidence that the mother had consented to the use of the psychotropic medications and corresponding BSP.		W 130	The QMRP will provide retraining to staff on each		
						4/3.108
	Based on observation that clients were pro-	s not met as evidenced by: on, the facility falled to ensure ovided privacy during care of one of the three clients in the		•		,
	The finding includes	57.				
	changing Client #2's undergarments (AP door wide opened.	et 3:25 PM, staff was observed s adult protective PU's) in her bedroom with the The direct care staff did not n my entry into the hallway.				

FORM CMS-2687(02-99) Previous Varaiona Obsolete

Event ID: HDMC11

Facility ID: 09G171

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 03/20/2008 FORM APPROVED OMB NO. 0938-03<u>91</u>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		09G171	B. WING		03/07/2008			
NAME OF PRO	OVIDER OR BUPPLIER		STREET ADDRESS, GITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002					
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X.I.) COMPLETION DATE		
W 148 W 148 T ppc T Effs W 153 W 153	loorway in clear viet to time during that no time during that are staff attempt to losing the door. 83.420(c)(6) COMPLIENTS, PARENT of the facility must no parents or guardian that grants or guardian that continuous interview alled to notify pare ignificant incidents are sample. (Clien the findings including the sample of the unusual locumented that Compensation on Marchael and the compensation of the	In the client's bedroom we of the client being changed, he observation did the direct o protect Client #2's privacy by IMUNICATION WITH TS & httify promptly the client's h of any significant incidents, or ht's condition including, but not liness, accident, death, abuse, sence. Is not met as evidenced by: hand record review, the facility hand record review, the facility hand record feven three clients in t #2) e: Hall incidents on March 5, htely 2:15 PM revealed an Hary 17, 2008. The incident Helient #3 hit Client #2 in the failed to indicate that the made aware of the incident. Qualified Mental Refardation arch 7, 2008 at 10:00 AM	W 148	The QMRP will provide refresher train staff on incident management, including notifications.		4/30/08		

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Mar. 31 2008 05:02PM P7/30 2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2008 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	COMPLETED	
		09G171	B. WING		03/07/2008	
NAME OF P	ROVIDER OR SUPPLIER	ŧ	17	EET ADDRESS, CITY, STATE, ZIP CODE 101 24TH STREET, NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE				
W 153	Continued From page 5 immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) one of the three clients in the facility. (Client #2)		W 153			
	2008, at approxim	unusual incidents on March 5, nately 2:15 PM revealed an		1. Sec response to W148.	4/30/08	
	documented that face. The incide:	nuary 17, 2008. The Incident Client #3 hit Client #2 in the nt failed to indicate that the State ts family or the administrator of the incident.	-			
	2008, at approximincident dated No documented that the face. The inc	unusual incidents on March 5, nately 2:15 PM revealed an evember 15, 2007. The incident Client #3 scratched Client #2 in cident failed to indicate that the made aware of the incident.		2. See response to W148.	4/30/08	
W 156	Professional on Macknowledged th	e Qualified Mental Retardation March 7, 2008 at 10:00 AM e deficient practice. AFF TREATMENT OF	W 156			
	The results of all to the administration	investigations must be reported tor or designated representative		See response to W148	4/30/08	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES :

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES	,				0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTI	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDIN	<u></u>		
		09G171	B. WII	NG		03/07	7/2008
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
CARECO	11				701 24TH STREET. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION 9HO CROSS-REPERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 156	Continued From pa	•	W	156			
		in accordance with State law days of the incident.					
	Based on record re ensure the results to the administrator	is not met as evidenced by: eview, the facility failed to of investigations were reported or or designee for two of the five the facility. (Clients #2 and #5)					
	The finding include	s '					
	reports on March 6 PM revealed an un 1, 2008, January 1 November 15, 200 The incidents were was no evidence th	sual incidents and invostigative , 2008, at approximately 2:15 usual incidents dated January 7, 2008, February 11, 2008, B, and November 26, 2007. Investigated, however, there hat the administrator was made is of the Investigations.					
W 159		FIED MENTAL	w	159			
	integrated, coordin	treatment program must be ated and monitored by a tandation professional,					2
,	Based on observation, the factorial Retardation Profes	is not met as evidenced by: ion, interview and record ility's Qualified Mental sional failed to monitor and a for the two of the three clients ents #1 and #2)					
		· ·					Į.

If continuation sheet Page 7 of 15

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Mar. 31 2008 05:02PM P9/30 Ø 011

> PRINTED: 03/20/2008 FORM APPROVED OMB NO. 0938-0391

ENTERS	S FOR MEDICARE OF DEFICIENCIES OGRECTION	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		(X3) DATE SI COMPLE	IRV É Y ITED
		099171	١ .			7/2008
AME OF PR	OVIDER OR SUPPLIER		} ,	REET ADDRESS, CITY, STATE, ZI 1701 24TH STREET, NE	- CODE	
CORRECO	11 .			WASHINGTON, DC 20002	CORRECTION	(X5)
(X4) ID PREFIX TAG	· Jevou ocelejejeMi'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
W 159	Continued From particles of the findings included		W 15	9		
	1 The OMRP fail	ed to ensure Client #1's day ment Individual Support Plan	· .	1. The QMRP will ensure to a current copy of the client	hat the Day Program h 's ISP in the record.	as 4/34/68
	staff on March 6, 1 revealed that ther Support Plan in the client's record ver information was beindicated that she for the client on F	w with Client #1's day program 2007 at 11:00 AM, it was e was no current Individual e clients record. Review of the lifed the same. When this rought to the QMRP, she had assumed the responsibility ebruary 11, 2008. She was not y program did not have the lents.				1
W 189	re-assessed by the hospitalization. (\$483.430(e)(1) ST	AFF TRAINING PROGRAM	W 1	2. The QMRP will arrang reassessed by the physical	ge for the chent to be	4/34/0
	employee to per efficiently, and co	ing training that enables the form his or her duties effectively, empetently.			<u> </u>	
	Based on obsether review the facility trained on safe to	o is not met as evidenced by: vation, interview and record v failed to ensure staff was ransfer techniques for one of the ne sample. (Client #1)		The QMRP will ensure that physical transfers.	staff are trained on sat	4/30/0
	The finding inclu	des:				
	ahean/ad heind	07 at 8:15 AM, Client #1 was transferred from the couch to her staff. Interview with the House				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	# MEDICAID SERVICES				OMB NO.	<u>0938-0391</u>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU(PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		09G171	B. WIN	IG		03/0	7/2008
NAME OF P	ROVIDER OR SUPPLIER	J		17	EET ADDRESS, CITY, STATE, ZIP CODE 701 24TH STREET, NE (ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
VV 189	Manager revealed Review of Client #1 assessment dated recommendation for safety. Although that she assisted the surveyor could not Manager's account	that the staff was newly hired. I's physical therapy May 14, 2007 revealed a or a two-person transfer for the House Manager indicated the staff with the transfer, the corroborate the House	w.				
W 210	Within 30 days after interdisciplinary teal assessments or re-	VIDUAL PROGRAM PLAN or admission, the or must perform accurate assessments as needed to eliminary evaluation conducted	Wa	210			
	Based on observat review, the facility f re-assessed by the ability to ambulate	is not met as evidenced by: ion, interview and record ailed to ensure clients were physical therapist after her decreased post hospitalization clients in the sample. (Client			•		
	re-assessed by the re-admitted to the f	d to ensure Client #1 was physical therapist after being acility as evidenced below: conducted March 5, 2008			1. The QMRP will ensure that client #1 reassessed by the Physical Therapist.	is	4/30/08
	being pushed in a value observed being wheelchair onto the physical therapy as	008, Client #1 was observed wheelchair by staff. She was grapositioned out of her couch. Review of the client's sessment dated May 14, 2007 onsultant recommended that					,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
MB NO. 0938-0391
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G171	B. WING		03/07/2008	
NAME OF PE	ROVIDER OR SUPPLIER		17	EET ADDRESS, CITY, STATE, ZIP CODE 101 24TH STREET. NE FASHINGTON, DC 20002		
(X4) ID PREFIX TAG	JEACH DESIGNATIONS	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	IDBE LEAMARCHOM I	
W 210	revealed that the cand she required the mobility. Interview retardation Profess 2008 at approximation that not been Therapist post hos the assessment/refacility, the QMRP have been re-asses re-admitted from the Client #1 had not be 12. The facility tailed feeding skills was	wheelchair only for wever, interview with the staff lient's condition had changed he use of a wheelchair for with the Qualified Mental sional (QMRP) on March 7, ately 10:40 AM revealed that the nire-assessed by the Physical pitalization. When asked what rassessment policy was for the indicated that the client should essed when she was ne hospital; and verified that	W 210	2. The QMRP will ensure that the clien skills are reassessed.	('s cating	
W 249	During the evening 2008, at 6:34 PM, The staff did not e Independently or v Observations at th 2008 at 11:50 PM, She fed herself indicate was brought to the Mental Retardation was no evidence to been re-assessed 483.440(d)(1) PROAS soon as the interpretation of th	g observation on March 5, staff fed Client #1 her dinner, necourage the client to eat with hand over hand assistance, e day program on March 6, Client #1 was eating her lunch dependently with staff assisting. The contrast in observations attention of the Qualified in Professional (QMRP). There hat Cilent #1's eating skills had DGRAM IMPLEMENTATION erdisciplinary team has	W 249	The QMRP will review and revise the a	etive	
	formulated a client each client must re treatment program interventions and	t's individual program plan, eceive a continuous active in consisting of needed services in sufficient number support the achievement of the	·	treatment program as needed, and provi to staff and the nurse in implementation documentation	de training and 4/35/08	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HDMC11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	FORM APPROVE
CENTERS FOR MEDICARE & MEDICAID SERVICES	OMB NO. 0938-039
OCIVICAL OF MEDICAL CONTROL OF A PROPERTY OF THE OCIVICAL OF T	***

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	A. BUILDING	PLE CONSTRUCTION	(X3) DATE 5 COMPL	BURVEY ETED
		09 G 171	B. WING		03/4	7/2008
NAME OF P	ROVIDER OR SUPPLIER		17	EET ADDRESS, CITY, STATE, ZIP 701 24TH STREET, NE 7ASHINGTON, DC 20002	CODE	
(X4) ID PREPIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	COMPLETION DATE
W 249	,	age 10 ad in the individual program	W 249			
	Based on observation, the fa	is not met as evidenced by: ation, staff interview and record cility failed to provide treatment for one of the three ple. (Clients #2)				
	The finding includ	ės .			-	
	5, 2008 at 5:37 Pt medicine. As the liquid lactulose, th you want me to po attempt to assist t medication, howe	ation pass observation on March M, Client #2 received her nurse was preparing to pour the c client asked the nurse, "do our it?" The nurse made an he client in pouring the ver due to the clients inability to he nurse poured the medication.		<u>-</u>	·	
	(IPP) revealed that improve her home to pour items of his prompts for three to the instructions the client in pouring over hand assista Qualified Mental F (QMRP) on March AM revealed that a day program go acknowledged the documenting the improve that when asked why	nts Individual Program Plan at Client #2 has a program to a management skills by learning or choice with 50% verbal consecutive months. According to the staff, they were to assisting the liquid item by using hand noc. Interview with the Retardation Professional 17, 2007 at approximately 10:45 the program was developed as al, however the QMRP agroup home staff were implementation of the program, the nurse did not implement the RP was unable to answer the				

FORM CMS-2867(02-99) Previous Versions Obsolete

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FAX NO. :

Mar. 31 2008 05:04PM P13/30

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PRINTED: 03/20/2008

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 03/07/2008 e, WING 09G171 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1701 24TH STREET, NE WASHINGTON, DC 20002 CARECO 11 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE (X4) IU REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) TAG 483.440(f)(3)(i) PROGRAM MONITORING & W 262 W 262 The OMRP will ensure that restrictive measures CHANGE recommended to help the clients manage behaviors The committee should review, approve, and are brought to the HRC for review and approval. 4/30/08 monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Human Rights Committee (HRC) failed to review and approve the use of restrictive measures, for two of the three clients in the sample. (Clients #1 and #3) The finding includes: On March 6, 2008 at approximately 1:00 PM, review of the HRC minutes and interview with the Qualified Mental Retardation Professional (QMRP) revealed that there was no evidence that the HRC had approved the use of restrictive techniques (i.e. behavior support plan and psychotropic medications) to manage behaviors for Clients #1 and #3 behaviors. [See W124] W 263 483.440(f)(3)(ii) PROGRAM MONITORING & W 263 CHANGE See response to W124.

FORM CMS-2567(02-99) Previous Versions Obsolete

minor) or legal guardian.

The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a

This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including

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4/30/08

Mar. 31 2008 05:04PM P14/30

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PRINTED: 03/20/2008 FORM APPROVED OMB NO. 0938-0391

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED <u>0938-0391</u>
TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY
		08G171	B. WIN	ю <u> —</u>		03/07	/2008
NAME OF P	ROVIDER OR SUPPLIER		•	17	EET ADDRESS, CITY, STATE, ZIP CODE 101 24TH STREET, NE ASHINGTON, DC 20002		·
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE l	(X5) COMPLETION DATE
W 322	conducted with the the client, parents in guardian for two of (Clients #1 and #3). The finding include The facility failed to the use of restrict Client #1 and #3's W124] 483.460(a)(3) PHY The facility must purpose and medical case of the contents of the contents were signed clients. (Client #3). The finding include Review of Client #3). The finding include Review of Client #3. Wise dated November and the policy required (PCP) sign telephore 482.460(a)(3)(iii) Finding Include Review of Client #3).	r modification drugs was written informed consent of (if the client is a minor) or legal the three clients in the sample. The three clients in the sample. So obtain informed consent prior ctive measures as described in Behavior Support Plan. [Sea Sician Services and are. SICIAN SERVICES rovide or obtain preventive and are. Is not met as evidenced by: eview and record review, the sure that clients physician d, timely for one of the three distributed by the Registered mber 28, 2007. The order did signature by the prescribing rector of Nursing stated that that the primary care physician one orders within 24-48 hours.] PHYSICIAN SERVICES	W	322	The RN Supervisor will ensure that all porders are appropriately and timely sign prescribing physician. The QMRP will ensure that all required	ed by the	4/3/08
		rovide or obtain annual physical			The QMRP will ensure that all required are performed per physician orders.	. Ino station	4/20/08

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examinations of each client that at a minimum

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING b. WING 09G171 03/07/2008 SYREET ADDRESS, CITY, STATE, ZIP-CODE NAME OF PROVIDER OR SUPPLIER 1701 24TH STREET, NE **CARECO 11** WASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION) PREFIX DATE TAG DAT DEFICIENCY) W 325 W 325 Continued From page 13 includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observations, staff interview and record verification, the facility failed to ensure recommended laboratory studies were obtained for clients, timely for one of the three clients in the sample, (Cilent #3) The finding includes: During the evening medication administration on March 5, 2008 at 4:39 PM, Client #3 was observed receiving Depakote 1000 mg. Interview with the medication nurse indicated that the client received the medication for her maladaptive behaviors. Review of the client's physician order dated January 2008 revealed an order for Depakote 500 mg every morning and 1000 mg every evening. The order further required Depakote levels studies 10 days after implementation of new dosage of Depakote. On January 29, 2008, the client's Depakote level was 41.0 (range 50-100). According to the February 20, 2008 Psychotropic medication review, the Psychiatrist recommended to repeat Depakote laboratory study if not within normal limits. At the time of the medical record review on March 6, 2008, the facility failed to repeat the study. The RN Supervisor will ensure that all medication W 331 W 331 483.460(c) NURSING SERVICES

FORM CMS-2557(02-RR) Previous Versions Obsolete

The facility must provide clients with nursing

This STANDARD is not met as evidenced by:

services in accordance with their needs.

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levels, ctc.)

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nurses are aware of and follow physician orders regarding medication administration and

surveillance (i.e., monitoring and reporting glucose

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARI	& MEDICAID SERVICES				<u>. 0938-0391</u>
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION	(X3) DATE S COMPLI	ETĘD
AND FEAR O	·		A. BUIL		03/0	7/2008
	ROYIDER OR SUPPLIËR	09G171	1	STREET ADDRESS, CITY, STATE, ZIP (1701 24TH STREET, NE		772005
CARECO	11	<u></u>		WASHINGTON, DC 20002		.,
(X4) JD PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	!L! PREF!! TAG		ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
W 331	Continued From p	age 14	w:	31		
	review, the facility physician of blood	tion, staff interview and record a nurse failed to inform the sugar fingerstick values as three clients in the sample.				
	The finding includ	es;				
W 436	nurse obtained a lastick from Client # nurse was asked, notified of a gluco that the physician sugar level of 250 current physician's 9:16 AM, revealed notified of blood s 60 or greater than note and interview revealed no evide notified the physic 238 as ordered by	at 4:39 PM, the medication blood sugar reading via finger 3. The reading was 238. The "when should the physician be se level?" The nurse indicated should be notified of a blood or greater. Review of the sorders on March 6, 2007 at a that the physician should be ugars if the readings are below 200. Review of the nursing with the Registered Nurse noe that the medication nurse ian of a finger stick reading of the physician.	W	136		
	and teach clients choices about the hearing and other and other devices	urnish, maintain in good repair, to use and to make informed use of dentures, eyeglasses, communications alds, braces, identified by the client.				
	Based on observe review, the facility furnished with rec	is not met as evidenced by: ation interview and record falled to ensure clients were commended adaptive equipment e clients in the sample. (Client				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE S COMPLE	
	,	09G171	B' MING		03/0	7/2008
NAME UF P	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE NASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BÉ	(X5) COMPLETION DATE
W 436	2008 through Marc observed without a glasses etc.). Revl March 6, 2008 at 1: ophthalmologist eve 13, 2007. At that ti glasses. Interview March 7, 2008 at a revoaled Client #2 wear them. When in place to encoura glasses, the nurse Retardation Profess there was no progre Client #2 to wear here was no progre Client #2 to wear here cord on March 5, 200 observations, Clien closed tight. Further ecord on March 6, Physical Therapist 2007. The assessments for the client the survey was Swarlient's hands. Inter March 7, 2008 at approximation of the client's hands. Inter March 7, 2008 at approximation of the client's hands. Inter March 7, 2008 at approximation of the client's hands. Inter March 7, 2008 at approximation of the client's hands. Inter March 7, 2008 at approximation of the client's hands. Inter March 7, 2008 at approximation of the client's hands.	ey conducted from March 5, h 7, 2008, Client #2 was ny adaptive equipment(i.e. ew of the client's record on 00 PM revealed the aluated the client on August me she was prescribed with the facility's nurse on opproximately 10:00 AM has glasses but refuses to asked if there was a program ge the client to tolerate her and Qualified Mental sional (QMRP) indicated that am in place to encourage er glasses. 28 during evening the was observed with her fist ar review of the client's medical 2008 at 10:47 AM, revealed a assessment dated April 19, ment recommended Swanson's hands. At no time during anson cones observed in the review with the QMRP on opproximately 9:30 AM verified at have the recommended	VV 436	1. The QMRP will develop a program client understand the need for her eye wear them; the QMRP will train staff and document the program. 2. The QMRP will obtain Swanson Censure staff are trained to assist the clithem.	glasses and to implement	4/36/08

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; HDMC11

Facility ID: 08G171

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(X3) DATE SURVEY (X2) MULTIFLE CONSTRUCTION (X1) PROVIDER/BUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CURRECTION A. BUILDING B. WING 03/07/2008 09G171 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1701 24TH STREET, NE WASHINGTON, DC 20002 CARECO 11 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1000 INITIAL COMMENTS 1 000 A re-licensure survey was conducted from March 5, 2008 through March 7, 2006 using the fundamental survey process. However due to deficient practices in the Condition of Participation of Active Treatment, the survey was extended to examine this condition. A random sample of three residents was selected from a residential population of five females with mental retardation and other disabilities. The findings of the survey were based on observations at the home and two day programs, interviews with clients and staff, and the review of records, including incident reports. 1043 3502.2(c) MEAL SERVICE / DINING AREAS 1 043 See response to federal deficiency W120. Modified diets shall be as follows: 4/30/08 (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the modified diet for one out of four residents in the sample had been reviewed at least quarterly by the consulting distitian for one of the three residents in the sample. (Resident #1) The finding includes: Review of Resident #1's nutritional assessment dated May 22, 2007 on March 6, 2007 at 9:56 AM revealed that the resident was recommended a 1500 calorie soft bite sized textured diet. Further review failed to show evidence that the facility's Nutritionist had reviewed Resident #1's diet on a Health Regulation Administistion TITLE (X6) DATE

DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE DULLAN

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN		(X3) DATE 51 COMPLE	JRVEY TED	
		09G171			······································	03/01	7/2008
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043		age 1 should be noted that	the	l 043			
	resident was admit November 24, 200 due to seizure activ a PEG tube was in hospital. Interview Retardation Profes	ted to the hospital on 7 through December vity. During the hosp serted for feeding wh with Qualified Mente sional (QMRP) ackno nutritional status had	5, 2007 italization, ille in the all owledged				
l 2 06	annually thereafter certification that a l performed and that	EL POLICIES for to employment ar shall provide a physhealth inventory has t the employee 's ha her to perform the re	sicien ' s been aith status i	1 206	The Human Resource Director we staff assigned to work at the faciliannual health assessment on file.	ity have a current	4/30/08
	Based on interview Home for Mentally	met as evidenced by and record review, in Retarded Persons (Cat all staff had currents:	the Group SHMRP)				
	revealed that one of review failed to sho annual health asset that two staff record	connel files on March of the nine charts pre ow evidence of a curr essment. It should be ds was not presente could not be determi ealth inventory.	esented for rent e noted d for				
Health Regu STATE FOR	lation Administration			85 9 9	HDMC11	If continual	lon street 2 of 13

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FORM APPROVED (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING a. WING _ 03/07/2008 09G171 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER.

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1701 24TH STREET, NE WASHINGTON, DC 20002

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1379	Continued From page 2		1379				
1379	3519.10 EMERGENCIES		ı 379				
	In addition to the reporting requirement in each GHMRP shall notify the Department Health, Health Facilities Division of any of unusual incident or event which substantinterferes with a resident 's health, welfarangement, well being or in any other will places the resident at risk. Such notification made by telephone immediately and stollowed up by written notification within twenty-four (24) hours or the next work division.	t of ther felly re, living ray on shall thall be		See response to federal deficiencies W148.	4/30/08		
	This Statute is not met as evidenced by: Based on interview record review, the Griden for Mentally Retarded Persons (Glifalled to ensure that the Administrator, wo notified of unusual incidents or events the substantially interfered with each residen and welfare within twenty-four hours or the work day.	roup HMRP) as at at					
	The findings include:						
	1. Review of the unusual incidents on M 2008, at approximately 2:15 PM revealed incident dated January 17, 2008. The indocumented that Resident #3 hit Resident he face. The incident failed to indicate the State Agency, the residents family or the administrator was made aware of the incident.	d an cident nt #2 in that the					
	2. Review of the unusual Incidents on M 2008, at approximately 2:15 PM revealed Incident dated November 15, 2007. The documented that Resident #3 scratched #2 in the face. The incident failed to indithe administrator was made aware of the	d a n : incident Resident Icate that					
Health Reg	ulation Administration		689D	HDMC11 If conti	guation sheet 3 of 1:		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			R/CLIA VIBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DAYE SURVEY COMPLETED	
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1 379	Continued From pa	age 3		1379			
,	incident.						
	Interview with the C Professional on Ma acknowledged the	Qualified Mental Reta arch 7, 2008 at 10:00 deficient practice.	rdation AM				
1 394	3520.2(d) PROFESSION SERVICES: GENERAL PROVISIONS			1 394	<u> </u>	_	
	professional staff to necessary profess accordance with the individual habilitation necessary by the in- professional service limited to, those set trained, qualified, a	ill have available quaito carry out and monitional interventions, in e goals and objective on plan, as determinated from the disciplinary teambers may include, but ervices provided by in and licensed as requial law in the following sof services:	tor I I I I I I I I I I I I I I I I I I I		The Human Resources Director with a current license for the nutritionist is	on file.	dos
	(d) Nutritian;		•				
	Based on record re Mentally Retarded provide nutritional	t met as evidenced beview, the Group Ho Persons (GHMRP) to monitoring to direct of sident's prescribed di necessary by the am.	me for alled to are staff	·	,		
	The finding include	es:					
		sonnel files on Marched that the GHMRP for for the nutritionist.					
1 397	PROVISIONS	SSION SERVICES:	GENERAL	1397	The Human Resources Director will c current license for the psychologist is	on file.	30/08
Health Regul	lation Administration M			6809	HDMC11	If continuation shee	et 4 of 10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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I 397	Continued From pa	age 4		1 397			
	professional staff to necessary professi accordance with the individual habilitation necessary by the in- professional servical limited to, those settrained, qualified, a District of Columbia disciplines or areas	I have avaitable qualic carry out and monitional interventions, in e goals and objective on plan, as determine terdisciplinary team, es may include, but rivices provided by in and licensed as require law in the following of services:	or es of every ed to be The not be dividuals				
	(g) Psychology;						
	Based on record re Mentally Retarded ensure that the lice	met as evidenced by eview, the Group Hor Persons (GHMRP) fi enses of all consultan end by District of Colu	ne for ailed to ts were				
	The finding includes:						
·	10:30 AM, revealed	onnel files on March d that the GHMRP fa or the psychologist.					
1 399	3520.2(i) PROFES PROVISIONS	SION SERVICES: G	ENERAL	1399			
Health Reco	professional staff to necessary professionaccordance with the individual habilitation necessary by the in professional service limited to, those se	If have available qual o carry out and monitional interventions, in seguals and objective on plan, as determinenterdisciplinary teams and incensed as required as required as required.	tor es of every ed to be The not be dividuals		The Human Resources Director will license for the Speech Pathologist is	ensure that a on file.	

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FORM APPROVED YAVRUE ATAG (EX) (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETE: AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/07/2008 09G171 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1701 24TH STREET, NE WASHINGTON, DC 20002 CARECO 11 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1399 1399 Continued From page 5 District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the licenses of all consultants were current and approved by District of Columbia Licensing Board. The finding includes: Review of the personnel files on March 7, 2008 at 10:30 AM, revealed that the GHMRP failed to provide a license for the Speech pathologist. 1400 1400 3520,2(j) PROFESSION SERVICES: GENERAL **PROVISIONS** The facility no longer engages the recreation specialist. Each GHMRP shall have available qualified professional staff to carry out and monitor. necessary professional interventions, in 4/30/08 accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals

Health Regulation Administration

(j) Recreation

trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:

This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the licenses of all consultants were current and approved by District of Columbia

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If continuation sheet 6 of 13

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(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 03/07/2008 **GBG171** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1701 24TH STREET, NE WASHINGTON, DC 20002 CARECO 11 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG DEFICIENCY TAG 1400 Continued From page 6 1400 Licensing Board. The finding includes: Review of the personnel files on March 7, 2008 at 10:30 AM, revealed that the GHMRP falled to provide a license for the recreation specialist, 1405 1405 3520,7 PROFESSION SERVICES: GENERAL See response to federal deficiency W120. **PROVISIONS** 4/30/08 Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers. including both public and private agencles and Individual practitioners. This Statute is not met as evidenced by: Based on observations, interview, and record verification, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that outside services met the needs for one of three residents include in the sample. (Resident #3) The finding includes: On March 5, 2008 at 6:20 PM, Resident #3 was observed eating a chopped dinner. On March 6, 2008 at approximately 12:00 PM, the resident was observed during lunch at her day program. The resident was observed eating a chopped chicken, whole black beans, greens and a whole dinner roll. Interview with the Qualified Mental Retardation Professional (QMRP) and Registered Nurse on March 6, 2008 at approximately 2:30 PM stated that the resident received a chopped diet due to her risk of aspiration. Review of the resident's current physician's order at 2:00 PM confirmed that the resident was required to Health Regulation Administration

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(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A, BUILDING DAIW # 03/07/2008 09G171 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1701 24TH STREET, NE WASHINGTON, DC 20002 CARECO 11 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETÉ BUMMARY STATEMENT OF DEPICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) IP (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1405 1 405 Continued From page 7 receive a chopped diet. 428 1 428 3521.5(e) HABILITATION AND TRAINING See response to federal deficiency W210. 4/34/08 Each GHMRP shall make modifications to the resident's program at least every six (6) months or when the client: (e) As indicated by a change in his or her health status. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure Resident #1 received a re-evaluation by a physical therapist after her ability to ambulate decreased. The findings include: 1. The facility failed to ensure Resident #1 was re-assessed by the physical therapist after being re-admitted to the facility as evidenced below: During the survey conducted March 5, 2008 through March 7, 2008, Resident #1 was observed being pushed in a wheelchair by staff. She was also observed being repositioned out of her wheelchair onto the couch. Review of the resident's physical therapy assessment dated May 14, 2007 revealed that the consultant recommended that the resident use the wheelchair only for transportation; however, interview with the staff revealed that the resident's condition had changed and she required the use of a wheelchair for mobility. Interview with the Qualified Mental retardation Professional (QMRP) on March 7, 2008 at approximately 10:40 AM revealed that the resident had not been re-assessed by the

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(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B, WING 03/07/2008 09G171 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1701 24TH STREET, NE WASHINGTON, DC 20002 **CARECO 11** (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1428 Continued From page 8 1428 Physical Therapist post hospitalization. When asked what the assessment/re-assessment policy was for the facility, the QMRP indicated that the resident should have been re-assessed when she was re-admitted from the hospital; and verified that Resident #1 had not been re-assessed. 2. The facility failed to ensure that Resident #1's feeding skills was assessed after being re-admitted to the facility as evidenced below: During the evening observation on March 5, 2008, at 6:34 PM, staff fed Resident #1 her dinner. The staff did not encourage the client to eat independently or with hand over hand assistance. Observations at the day program on March 6, 2008 at 11:50 PM, Resident #1 was eating her lunch. She fed herself independently with staff assisting to wipe her mouth. The contrast in observations was brought to the attention of the Qualified Mental Retardation Professional (QMRP). There was no evidence that Resident #1's eating skills had been re-assessed. 1430 1430 3521.7(a) HABILITATION AND TRAINING Sec response to federal deficiency W436. The habilitation and training of residents by the 4/30/08 GHMRP shall include, when appropriate, but not he limited to, the following areas: (a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils); This Statute is not met as evidenced by: Based on observation, staff interview and record

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review, the Group Home for Mentally Retarded Persons (GHMRP) failed to train residents to use

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	in the sample. (R The findings inclu 1. During the aur 2008 through Mai observed without glasses etc.). Re March 6, 2008 at ophthalmologist 6 13, 2007. At that glasses. Intervier March 7, 2008 at revealed Resider wear them. Whe in place to encou glasses, the nure Retardation Profe there was no pro Resident #2 to w 2. On March 5, 2 observations, Re fist closed tight. medical record o revealed a Physi April 19, 2007. I Swanson cones time during the s observed in the r the QMRP on Ma 9:30 AM verified	ent for one of the three tesident #2) Ide: Vey conducted from rich 7, 2008, Resident any adaptive equipmediew of the resident's 1:00 PM revealed the valuated the resident time, the client was wow with the facility's not approximately 10:00 at #2 has glasses but an asked if there was rage the resident to the and Qualifled Mentessional (QMRP) indigram in place to enco	March 5, t #2 was nent(i.e. s record on e ton Augus prescribed urse on ton AM; refuses to a program tolerate her tal icated that ourage ved with he resident's 0:47 AM, ment dated hds. At no cories erview with eximately			
l 4 36	The habilitation a	ITATION AND TRAIL and training of reside	nts by the	I 436	See response to federal deficiency W249.	4/20/08

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(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND FLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING. 03/07/2008 09G171 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1701 24TH STREET, NE WASHINGTON, DC 20002 CARECO 11 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PRÉFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG 1436 1436 Continued From page 10 (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the habilitation and training to residents in the domain of self medication for one of the three residents in the sample, (Resident #2) The finding includes: During the medication pass observation on March 5, 2008 at 5:37 PM, Resident #2 received her medicine. As the nurse was preparing to pour the liquid lactulose, the resident asked the nume. "do you want me to pour it?". The nurse made an attempt to assist the resident in pouring the medication, however due to the residents inability to grasp the bottle, the nurse poured the medication. Review of the residents Individual Program Plan (IPP) revealed that Resident #2 has a program to Improve her home management skills by learning to pour items of her choice with 50% verbal prompts for three consecutive months. According to the instructions to the staff, they were to assist the resident in pouring the liquid item by using hand over hand assistance. Interview with the Qualified Mental Retardation Professional (QMRP) on March 7, 2007 at approximately 10:45 AM revealed that the program was developed as a day program goal, however the QMRP acknowledged the group home staff were documenting the implementation

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(X3) DATÉ SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED : IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING B. WING 03/07/2008 09G171 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1701 24TH STREET, NE WASHINGTON DC 20002 CARECO 11 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MIJST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (436 Continued From page 11 1436 of the program. When asked why the nurse did not implement the program, the QMRP was unable to answer the question. 1 441 1441 3521.7(k) HABILITATION AND TRAINING See response to federal deficiency W189. The habilitation and training of residents by the 4/30/08 GHMRP shall include, when appropriate, but not be limited to, the following areas: (k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility equipment); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the habilitation of its residents included training in the area of mobility for one of the three residents in the facility. (Resident #2) The finding includes: On March 6, 2007 at 8:15 AM, Resident #1 was observed being transferred from the couch to her wheelchair by a staff. Interview with the House Manager revealed that the staff was newly hired. Review of Resident #1's physical therapy assessment dated May 14, 2007 revealed a recommendation for a two-person transfer for safety. Although the House Manager indicated that she assisted the staff with the transfer, the surveyor could not corroborate the House Manager's account. 1500 1500 3523,1 RESIDENT'S RIGHTS Each GHMRY residence director shall ensure

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G171 03/07/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE CARECO 11 WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X3) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ... PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG REFICIENCY) 1500 Continued From page 12 1.500 that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. The findings include: 1. The GHMRP falled to establish a system that See response to federal deficiency W124. 4/34/08 would ensure residents that were informed of the risks and benefits of their medications. [See Federal Deficiency Citation W124] The GHMRP failed to ensure its Human Rights Committee (HRC) reviewed and approved See response to federal deficiency W262, the use of restrictive measures. [See Federal Deficiency Citation W262] Health Regulation Administration STATE FORM

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